

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Laclede
Township Smith
or
Village
or
City

Registration District No. 277
Primary Registration District No. 5611

File No. 2150
Registered No. 1

(NO. _____ St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Clifford Franklin Arnold

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(If write the word)

DATE OF BIRTH

12 18 1910
(Month) (Day) (Year)

AGE

____ yrs. ____ mos. 2 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 0

BIRTHPLACE

(City or town, State or foreign country) Laclede Co Mo

PARENTS

NAME OF FATHER

Ben. F. Arnold

BIRTHPLACE OF FATHER

(City or town, State or foreign country) Cassidy Co Mo

MAIDEN NAME OF MOTHER

Cara Long

BIRTHPLACE OF MOTHER

(City or town, State or foreign country) Laclede co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. P. [Signature]

(ADDRESS) Stoutland Mo

Filed Jan 7 1911 C. K. E. [Signature]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

12 21 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from

____, 191____, to ____ 191____,

that I last saw him alive on 12 - 19 - 1910,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth
157

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory

(SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. E. P. [Signature] M. D.

12 21 1910 (Address) Stoutland

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. 2 ds. In the ____ yrs. ____ mos. 2 ds.

Where was disease contracted if not at place of death? at place of birth

Former or usual residence none

PLACE OF BURIAL OR REMOVAL

Barnett Cemetery

DATE OF BURIAL

12 21 1910

UNDERTAKER

none

ADDRESS

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

